Supreme Court, U.S.
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No. 96-1375

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Petitioner,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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JOINT APPENDIX

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PETITION FOR CERTIORARI FILED FEBRUARY 27, 1997
CERTIORARI GRANTED JUNE 2, 1997

40 P

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NOTICE

The following documents have been omitted in the printing of this Appendix. They may be found in the Appendix to the Petition for Writ of Certiorari at the following pages:

Opinion of the United States Court of Appeals for the Eighth Circuit	1a
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DOCKET ENTRIES

United States District Court
for the District of Minnesota

DATE	NO.	PROCEEDINGS
12/1/94	1	COMPLAINT—Summons issued. Assigned to Judge Richard H. Kyle per master list and referred to Magistrate Judge Ann D. Montgomery. (18 pages) (ps) [Entry date 12/02/94]
12/2/94	2	RETURN OF SERVICE executed upon U. S. Atty on 12/2/94. (3 pages) Summons not returned. (ps) [Entry date 12/21/94]
1/17/95	3	SUMMONES filed. (affidavits previously filed) 6 pages (ps)
1/25/95	5	MOTION by defendant to extend time to answer complaint. (to Magistrate Judge Ann D. Montgomery) 4 pages (ps) [Entry date 01/27/95]
1/26/95	4	ANSWER. (6 pages) (ps) [Entry date 01/27/95]
1/27/95	—	Referred Neil H. Koslowe to clerk to send government admission papers. (ps)
1/27/95	—	Referred Glenn W. Kendall to clerk to send government admission papers. (ps)
2/7/95	6	PETITION AND ORDER for admission pro hac vice (Clerk Francis E. Dosal) on behalf of defendant by Neil H. Koslowe. (1 page) (ps)
3/9/95	7	ORDER REGARDING FILING REPORT OF RULE 26(f) MEETING (Magistrate Judge Ann D. Montgomery 3/8/95) due no later than April 21, 1995. (4 pages) (ps)

DATE	NO.	PROCEEDINGS
3/17/95	8	MOTION by plaintiff to admit Ronald Sutter pro hac vice. (3 pages) (ps) [Entry date 03/20/95]
3/31/95	9	TRANSCRIPT. —separate— (ps) [Entry date 04/04/95]
4/3/95	10	PETITION AND ORDER for admission pro hac vice (Clerk Francis E. Dosal) on behalf of plaintiff by Ronald N Sutter (2 pages) (ps) [Entry date 04/05/95]
4/13/95	11	JOINT REPORT OF RULE 26(f) MEETING. (5 pages) (ps)
5/17/95	12	MOTION by plaintiff for summary judgment. (to Judge Richard H. Kyle) ret. 7/31/95 at 8:00 a.m. (3 pages) (ps) [Entry date 05/18/95]
5/17/95	13	MEMORANDUM and EXHIBITS by plaintiff in support of motion for summary judgment. [12-1] 44 pages (ps) [Entry date 05/18/95]
5/17/95	14	AFFIDAVIT and EXHIBITS of Kent G. Harbison regarding motion for summary judgment. [12-1] 50 pages (ps) [Entry date 05/18/95]
6/8/95	15	MOTION by defendant for summary judgment. (to Magistrate Judge Ann D. Montgomery) 1 page (ps) [Entry date 06/09/95]
6/8/95	16	MEMORANDUM by defendant in support of motion for summary judgment and MEMORANDUM in opposition to plft's motion for summary judgment. [15-1] 34+ pages (ps) [Entry date 06/09/95]
6/28/95	17	MEMORANDUM by pltf in opposition to dft's motion for summary judgment [12-1] 35pgs (pk) [Entry date 06/30/95]

DATE	NO.	PROCEEDINGS
6/28/95	18	EXHIBITS ACCOMPANYING PLTF'S MEMORANDUM 19pgs (pk) [Entry date 06/30/95]
7/11/95	19	MOTION by defendant for summary judgment. (to Judge Richard H. Kyle) ret. 7/31/95 at 8:00 a.m. [2 pages] (ps)
7/17/95	20	CONSENT MOTION by defendant to extend time file reply. (to Magistrate Judge Ann D. Montgomery) 3 pages (ps) [Entry date 07/19/95]
7/17/95	21	ORDER (Judge Richard H. Kyle 7/17/95) granting deft's motion to extend time to file reply to 7/26/95. [20-1] (cc: all counsel) 1 page (ps) [Entry date 07/19/95]
7/26/95	22	REPLY MEMORANDUM by defendant to plaintiff's memorandum [17-1] in opposition to defendant's motion for summary judgment (33 pgs) (dl) [Entry date 07/27/95]
7/31/95	23	MINUTES: (Judge Richard H. Kyle / Angie Threlkeld) taking under advisement deft's motion for summary judgment. [19-1] 1 page (ps)
8/8/95	24	MEMORANDUM OPINION AND ORDER (Judge Richard H. Kyle 8/8/95) granting deft's motion for summary judgment [19-1] [15-1]; denying pltf's motion for summary judgment [12-1]; and pltf's complaint is dismissed with prejudice. (cc: all counsel) 6 pages (ps) [Entry date 08/09/95]
8/8/95	25	JUDGMENT entered. (1 page) (ps) [Entry date 08/09/95]
10/2/95	26	NOTICE OF APPEAL by plaintiff St. Paul-Ramsey Med from Judge Richard H. Kyle decision dated 8/8/95 [24-2], receipt number 122373 (2pgs.). (lg)

DATE	NO.	PROCEEDINGS
10/2/95	—	DELIVERED TWO CERTIFIED and one uncertified copy of each of the following to the Court of Appeals, St. Paul Office: Notice of Appeal, Order, Judgment and District Court Clerk's Docket Entries. Copy of Notice of Appeal mailed to counsel (lg)
10/6/95	—	NOTIFICATION BY CIRCUIT COURT of Appellate Docket Number 95-3477MNST Filed 10/2/95 Doc. #26. (pk) [Entry date 10/10/95]

DOCKET ENTRIES

United States Court of Appeals
for the Eighth Circuit

DATE	PROCEEDINGS
10/5/95	Civil Case Docketed. (jmb)
10/5/95	CERTIFIED copies notice of appeal, docket entries, order and judgment of 8/08/95. [95-3477] [625503] (jmb)
10/5/95	BRIEFING SCHEDULE: DR aplnt due on 10/16/95 Method of Apndx due on 10/16/95 DR aplee due on 10/25/95 Administrative Record or Transcript due 11/14/95 ; Appendix due on 11/14/95 ; Brief of aplee due on 12/14/95 ; Reply brief due on 12/28/95 (jmb)
10/16/95	APPEARANCE for appellant, attorney Ronald N. Sutter [95-3477] [629056] (sek)
10/16/95	DESIGNATION of record received from Appellant St. Paul Ramsey. Type of appendix: JOINT APPENDIX [95-3477] (sjo)
11/2/95	APPEARANCE for appellee, attorney Neil H. Koslowe [95-3477] [635606] (jmb)
11/20/95	BRIEF FILED—Brief of Appellant- St. Paul Ramsey 44 pgs w/addendum—11 copies—w/service 11/14/95 . Defects: Standard of Review [95-3477] [642396] (sjo)
11/20/95	RECORDS received: Joint Appendix, consisting of 1 Volume(s) 3 copies. [95-3477] (sjo)
11/20/95	RECORDS received: Administrative Record consisting of 1 Volumes 3 copies [95-3477] (sjo)
12/13/95	Brief Correction(s) received from Appellant St. Paul Ramsey. Correction(s): Standard of Review. [95-3477] (sjo)

DATE	PROCEEDINGS
12/15/95	BRIEF FILED—Brief of Appellee—Donna E. Shalala. 37 pgs—w/addendum—10 copies—w/ service 12/14/95, Type Size & Addendum okay per MEG. [95-3477] [652165] (yml)
12/15/95	MOTION of aplnt, St. Paul Ramsey, for extension of time to file reply brief until 1/8/96 . [95-3477] [652730] w/service 12/14/95 (skh)
12/19/95	ORDER filed: granting appellant motion extension of time to file reply brief. [652730-1] [652731] Reply brief now due on 1/8/96 . (skh)
12/29/95	TO SCREENING—to St. Paul [95-3477] (smg)
1/12/96	MOTION of aplnt, St. Paul Ramsey, to file brief out of time [95-3477] [661309],—NO ACTION TAKEN. (brief timely filed) w/service 1/10/96 (sjo)
1/12/96	BRIEF FILED—Reply brief—St. Paul Ramsey . 25 pgs—11 copies—w/service 1/10/96 . [95-3477] [661312] (sjo)
1/12/96	RETURNED from Screening (15) [95-3477] (smg)
5/6/96	*SET FOR ARGUMENT*—June in St. Paul. [95-3477] (mel)
6/14/96	ARGUED AND SUBMITTED IN ST. PAUL TO JUDGES James B. Loken, Circuit Judge, Donald R. Ross, Circuit Judge, David R. Hansen, Circuit Judge . Ronald N. Sutter for Appellant St. Paul Ramsey . Neil H. Koslowe for Appellee Donna E. Shalala . Rebuttal by: Ronald N. Sutter . RECORDED. [95-3477] (lcd)
7/26/96	THE COURT: James B. Loken, Donald R. Ross, David R. Hansen . PER CURIAM OPINION FILED: PUBLISHED [95-3477] [737613] (paw)

DATE	PROCEEDINGS
7/26/96	JUDGMENT: James B. Loken, Donald R. Ross, David R. Hansen : The judgment of the lower court is AFFIRMED in accordance with the opinion. [95-3477] [737618] (paw)
9/9/96	PETITION for rehearing by the panel, filed by Appellant St. Paul Ramsey w/service 9/6/96, TO COURT. [96-3477] (lcd)
9/10/96	ERRATA sheet received for rehearing petition filed by Appellant St. Paul Ramsey . [95-3477] (lcd)
9/30/96	JUDGE ORDER: denying petition for panel rehearing [754556-1] filed by St. Paul Ramsey [95-3477] [762552] (lcd)
10/9/96	MANDATE ISSUED [95-3477] (lcd)
10/15/96	RECEIPT for Mandate. [95-3477] [768222] (lcd)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

No. 3-94-1522

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
640 Jackson Street, St. Paul, Minnesota 55101,
Plaintiff,

v.

DONNA E. SHALALA, Ph.D.,
Secretary, Department of Health and Human Services,
200 Independence Avenue, S.W., Room 614-G,
Washington, D.C. 20201,
Defendant.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF AND FOR SUMS DUE UNDER THE MEDICARE STATUTE

Plaintiff states:

I. INTRODUCTION

1. This suit challenges the validity of a Medicare regulation of extraordinary retroactive effect issued by the Secretary of the Department of Health and Human Services ("the Secretary"). Application of this regulation has caused plaintiff and many other teaching hospitals across the country great financial harm and prejudice.

2. In April 1986, Congress enacted a new Medicare payment methodology for graduate medical education ("GME") costs, effective for hospital cost reporting years beginning on or after July 1, 1985. Payment under this methodology (common known as the "GME per resident

amount" methodology) is based on "the average amount [per resident] recognized as reasonable under [the Medicare statute] for direct graduate medical education costs of the hospital" for a base year, updated for inflation and multiplied by the hospital's number of full-time equivalent residents in each subject year. The base year is each hospital's Medicare cost reporting year beginning in federal fiscal year 1984, during which year Medicare reimbursed teaching hospitals the "reasonable cost" of GME.

3. Plaintiff's base year was its 1984 fiscal year (*i.e.*, its cost reporting year beginning January 1, 1984, and ending December 31, 1984). Utilizing the "reasonable cost" standards then in effect, the hospital's Medicare intermediary (the Secretary's agent) completed the *final* audit for that year on February 28, 1986. As of March 1, 1989, the Secretary was legally precluded from reopening the hospital's 1984 fiscal year.

4. The Secretary did not promulgate regulations to implement the GME statute until September 1989, three and a half years after the statute's enactment. Contrary to the statute, these regulations do not require that payment under the GME per resident amount methodology be based on the amount of GME costs "recognized as reasonable" for the base year. Instead, even though hospital base years were closed and no longer subject to reopening under long-established Medicare principles and even though hospitals were no longer required even to retain the supporting documentation for their base year, the regulations authorized the Medicare intermediaries to reaudit a hospital's base year for purposes of the GME per resident amount methodology and use the results of the reaudit, rather than the results of the *final* audit applicable to the GME base year itself, to compute payment under the GME per resident amount methodology. The Secretary thereafter issued lengthy instructions to be used for the reaudits that significantly altered the "reasonable

cost" reimbursement standards in effect during the base year.

5. In late 1990, pursuant to the Secretary's GME "reaudit" regulations, plaintiff's Medicare intermediary began reauditing plaintiff's 1984 cost reporting year for purposes of the GME per resident amount methodology. In doing so, the intermediary retroactively applied the rigorous new standards in the Secretary's 1990 instructions. Not surprisingly under all these circumstances, the determination of plaintiff's allowable GME base year costs that the intermediary eventually issued in 1991 as a result of the reaudit was significantly lower than the determination it issued in 1986 in the final audit for the base year itself. The Secretary has used, and continues to use, the 1991 reaudit determination (rather than the 1986 determination applicable to the base year itself) to compute plaintiff's payment entitlement under the GME per resident amount methodology for the hospital's 1986 and subsequent cost reporting years.

6. Plaintiff contends that the Secretary's "reaudit" regulations are contrary to the Medicare statute, violative of well-established proscriptions against retroactive rulemaking, arbitrary and capricious, and otherwise contrary to law. Plaintiff seeks, among other things, an order invalidating the Secretary's "reaudit" regulations and requiring the Secretary to use the GME costs "recognized as reasonable" in the *final* audit applicable to the GME base year itself to compute payment under the GME per resident amount methodology.

II. JURISDICTION AND VENUE

7. This action arises under title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.* (the "Medicare statute"), and the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.*

8. This Court has jurisdiction under 42 U.S.C. § 1395oo(f)(1) and 28 US.C. §§ 1331 and 1361.

9. Venue lies in this judicial district pursuant to 42 U.S.C. § 1395oo(f)(1) and 28 U.S.C. § 1391.

III. PARTIES

10. Plaintiff is a not-for-profit teaching hospital located in St. Paul, Minnesota. It furnishes hospital services under the Medicare program.

11. Donna E. Shalala is the Secretary of the Department of Health and Human Services, the federal department responsible for the administration of the Medicare program.

IV. GENERAL BACKGROUND

12. The Medicare statute establishes a system of health insurance for most individuals aged 65 or over, for disabled persons who meet certain qualifications, and for individuals suffering end-stage renal disease who meet certain qualifications. 42 U.S.C. § 1395c. Pursuant to 42 U.S.C. § 1395cc, plaintiff entered into a written agreement with defendant to provide hospital services to eligible individuals.

13. For cost reporting years beginning before October 1, 1983, the Medicare program reimbursed *all* hospital services on a "reasonable cost" basis. 42 U.S.C. § 1395f(b). Reasonable cost is defined as the "cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, [to] be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services." 42 U.S.C. § 1395x(v)(1)(A).

14. In prescribing regulations to determine "reasonable cost," the Secretary is directed by 42 U.S.C. § 1395x(v)(1)(A) to take into account both the direct and indirect costs of providers of services; to consider, among other

things, the principles generally applied by national organizations or established pre-payment organizations in making third-party payments for medical care; and to ensure that "the necessary costs of efficiently delivering covered services to individuals covered by the [Medicare] program . . . will not be borne by individuals not so covered. . . ." Regulations have been issued by the Secretary to implement the reasonable cost provisions of the Medicare statute. *See* 42 C.F.R. arts 405, 413.

15. Allowable costs under the "cost reimbursement" system are generally apportioned to Medicare in accordance with a provider's Medicare utilization rate, *i.e.*, the proportion of a hospital's services used by Medicare patients. For instance, if a hospital furnished 30% of its services to Medicare patients, Medicare would reimburse approximately 30% of the hospital's allowable costs.

16. Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective payment system to reimburse most hospitals for inpatient *operating* costs. However, Congress retained the "reasonable cost" reimbursement system for certain hospital costs, including outpatient, medical education, and capital costs.

17. The prospective payment system for operating costs provided for a four-year transition period during which payment was based in part on a hospital-specific rate. *See Georgetown University Hospital v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988). The hospital-specific rate was defined as each hospital's "allowable operating costs of inpatient hospital services [per discharge] . . . recognized under this title" for a base period, adjusted for inflation. 42 U.S.C. § 1395ww(b)(3)(A). After the transition period, payment under the prospective payment system for operating costs has been based on a national rate per Medicare discharge, subject to numerous adjustments. 42 U.S.C. § 1395ww(d).

V. THE MEDICARE CLAIMS AND APPEALS PROCESS

18. The Secretary has contracted out many of her audit and payment functions to organizations (usually insurance companies) known as fiscal intermediaries.

19. At the close of a fiscal year, a provider of services must submit to its intermediary a "cost report" showing both the costs incurred by it during the fiscal year and the appropriate share of those costs to be apportioned to Medicare. 42 C.F.R. §§ 413.20(b), 413.24(f). The intermediary is required to analyze and audit the cost report and inform the provider of a final notice of program reimbursement ("NPR"). 42 C.F.R. § 405.1803.

20. A provider dissatisfied with its intermediary's determination may file an appeal with an administrative body called the Provider Reimbursement Review Board ("PRRB" or "Board") within 180 days of the date of the NPR. Section 1878(a) of the Social Security Act ("the Act"), 42 U.S.C. § 1395oo(a).

21. The PRRB lacks the authority to rule on the validit of a Medicare regulation. It is legally required to comply with all of the Secretary's Medicare regulations. 42 C.F.R. § 405.1867; *Bethesda Hospital Association v. Bowen*, 108 S. Ct. 1255, 1259 (1988).

22. A provider that has filed an appeal with the Board may ask the Board to determine that it lacks the authority to decide "a question of law or regulations relevant to the matters in controversy." Section 1878(f)(1) of the Act (third and fourth sentences), 42 U.S.C. § 1395oo(f)(1). Such a request is generally known as an expedited judicial review ("EJR") petition.

23. If the Board determines that it lacks the authority to decide the issue raised by the provider in its EJR petition, a provider may obtain judicial review of that

issue by filing a court suit within sixty days of receipt of the Board's EJR determination. Section 1878(f)(1) of the Act (third sentence).

VI. THE GME PER RESIDENT AMOUNT PAYMENT METHODOLOGY

24. In 1986, Congress enacted section 1886(a) of the Act, 42 U.S.C. § 1395ww(h), which radically altered the Medicare payment methodology for graduate medical education costs. Pub. L. No. 99-272, § 9202. Effective with cost reporting years beginning on or after July 1, 1985, the new legislation provided that each hospital would be paid the reasonable cost per resident incurred in its base period (its cost reporting year beginning in federal fiscal year 1984), updated by an inflation factor and multiplied by the current number of full-time-equivalent residents. *Id.*

25. The GME per resident amount methodology in section 1886(h) of the Act is a prospective payment system, a fact obscured by the Secretary's implementation of the provision. Under the GME statute, payment for GME is no longer based on the "reasonable costs" incurred by a hospital during each cost reporting year, as in the past. Rather, a hospital's GME payment rate for a particular year is based on costs per resident incurred prior to the effective date of section 1886(h) of the Act. The GME per resident amount methodology is, in effect, a prospective payment system for GME that bases payment entirely on a hospital-specific rate instead of a national rate.

26. On September 29, 1989, the Secretary issued regulations to implement the new GME statute. 54 Fed. Reg. 40,287-40,321, adopting 42 C.F.R. § 413.86.

27. By that date, the Medicare intermediaries had already audited, and issued NPRs for, the year to be used as the GME base year for virtually all hospitals in the country. In many cases, an NPR had been issued for the

GME base year more than three years previously. Long-established Medicare regulations preclude the reopening of a Medicare cost report more than three years after issuance of the original NPR for a cost reporting year. *See* 42 C.F.R. § 405.1885(a); Provider Reimbursement Manual § 2931.1.A.; Intermediary Manual § 2631.1.A; PRRB Dec. No. 80-D12, *Community Health Services of Crawford County, Inc.*, CCH Medicare and Medicaid Guide ¶ 30,459 (1980).

28. Under "reasonable cost" principles, hospitals were entitled to claim physician services devoted to approved medical education programs as allowable GME costs. *See* 48 C.F.R. § 405.481. They were required to "[m]aintain the time records or other information . . . used to allocate physician compensation" in auditable form for a period of *"four years* after the end of each cost reporting period to which the allocation applies." 42 C.F.R. § 405.481(g)(1), (3) (emphasis added). By the time that the Secretary issued the GME per resident amount regulations, the four-year record retention period for the GME base year was over, and hospitals were no longer required to retain supporting documentation for that period.

29. Nonetheless, the Secretary's GME regulations do not direct the intermediaries to compute a hospital's payment amount under the GME per resident amount methodology by using the amount recognized as reasonable for direct graduate medical education costs in the hospital's audited base year cost report issued with the hospital's base year NPR. Rather, the regulations authorize the Medicare intermediaries to reaudit a hospital's base year. 42 C.F.R. § 413.86(e)(1)(ii). The preamble to the final rule states:

> We would like to assure all interested parties that no new reimbursement principles will be applied during the reaudit. Rather, our intent is to ensure that the

reimbursement principles in effect during the GME base year were correctly applied.

54 Fed. Reg. 40,301 (col. 2) (1989).

30. The regulations state that, if a hospital's cost report for its GME base year is no longer subject to reopening under 42 C.F.R. § 405.1885, the Medicare intermediary may apply the results of its reaudit *only* for purposes of the GME per resident amount methodology. 42 C.F.R. § 413.86(e)(1)(iii). The intermediary may not, in this instance, apply the results of the reaudit to the GME base year cost report itself. *Id.*; *see also* 54 Fed. Reg. 40,301 (1989). Accordingly, the regulations allow the Medicare intermediaries to compute payment under the GME per resident amount methodology using a reasonable cost determination for the GME base year that is different from the amount recognized as reasonable in the audited cost report for the GME base year itself.

31. Nowhere in the preamble to the final rule did the Secretary cite any language in section 1886(h) of the Act, or in the accompanying legislative history, that allows the Secretary to reaudit a hospital's base year cost report for purposes of the GME per resident amount methodology or that allows the Secretary to use a base year "reasonable cost" determination for purposes of the GME per resident amount methodology that deviates from the Secretary's "reasonable cost" GME determination for the base year itself.

32. Despite the assurance given by the Secretary in the preamble in the final GME per resident amount regulation (quoted above), the Secretary did not simply tell the Medicare intermediaries to reaudit the GME base year using the same reimbursement principles in effect during that year (*i.e.*, during federal fiscal year 1984). Instead, in 1990, the Secretary issued a 24-page, single-spaced set of instructions that specify the standards that the Medicare intermediaries were to use in reauditing the base years. In addition, also in 1990, the Secretary issued a 34-page, single-spaced set of questions and answers to be applied

by the intermediaries in their reaudits. The Secretary's reaudit instructions and questions and answers adopted harsh new standards not in effect during the GME base year itself. Consequently, in virtually all cases, the intermediaries' "reasonable cost" determinations in the reaudits of the GME base year performed for purposes of the GME per resident amount methodology were significantly lower than the determinations in the audit done for the base years themselves.

33. The Medicare GME per resident amount regulations required the Medicare intermediaries, after completing their reaudits, to issue to each hospital a notice of "its base-period average per resident amount." 42 C.F.R. § 413.86(e)(1)(v). Hospitals have 180 days from the date of this notice to file an appeal with the PRRB. *Id.*

34. Plaintiff does not object to the Secretary applying the GME per resident amount methodology to its cost reporting years beginning on or after July 1, 1985. However, plaintiff does object to the Secretary doing so by using the reasonable cost determination from the GME reaudit. Plaintiff contends that the Secretary is legally required to use the reasonable cost determination from the *final* audit applicable to the GME base year itself.

VII. FACTS SPECIFIC TO THE PLAINTIFF

35. Plaintiff's GME base year is its fiscal year ending December 31, 1984. The hospital's Medicare intermediary audited that year and subsequently issued an NPR on February 28, 1986.

36. Three years passed after issuance of the NPR for plaintiff's 1984 cost reporting year without a reopening related to medical education costs. Accordingly, as of March 1, 1989 (three years and one day after issuance of the NPR), the Secretary's reopening regulations prohibited the Secretary from reopening plaintiff's 1984 cost report. 42 C.F.R. § 405.1885.

37. Plaintiff's GME base year closed on December 31, 1984. Accordingly, as of January 1, 1989 (four years

and one day later), the hospital was no longer even legally required to retain the physician allocation documentation supporting the GME claims in its GME cost report. *See* 42 C.F.R. § 405.481(g)(1), (3).

38. Notwithstanding the facts recited in the previous two paragraphs, plaintiff's Medicare intermediary began reauditing plaintiff's base year in late 1990 for purposes of the GME per resident amount methodology. On February 18, 1991, the intermediary issued a notice of average per resident amount for the hospital's base year. The intermediary determined therein that the hospital's allowable GME base year costs under "reasonable cost" principles were $5,412,686—an amount that is significantly lower than its determination in the final audit for fiscal year 1984 itself. As a result of the intermediary's determination, the hospital's Medicare reimbursement for its graduate medical education costs has been, and continues to be, substantially less than the amount to which it is entitled for its 1986 and all subsequent cost reporting years.

39. Consistent with 42 C.F.R. § 413.86(e)(1)(iii), the hospital's Medicare intermediary has not attempted to apply the reaudit results directly to plaintiff's base year (its 1984 fiscal year). Plaintiff's GME payment for the base year continues to be based on the "reasonable cost" determination in the base year audit completed in February 1986 rather than the "reasonable cost" determination in the 1991 reaudit. However, the Medicare intermediary has used, and continues to use, the 1991 reaudit determination (rather than the 1986 determination applicable to the base year itself) to apply the GME per resident amount methodology to plaintiff's 1986 and subsequent cost reporting years.

40. Plaintiff timely appealed the intermediary's notice of average per resident amount to the PRRB. Plaintiff's appeal challenged, among other things, the legality of the Secretary's reaudit regulations. Plaintiff contended that where (as here) the GME base year is no longer subject

to reopening, the intermediary must apply the determination of allowable GME costs in the audited GME base year cost report in determining the per resident amount under section 1886(h) of the Act. Plaintiff contended that the Secretary's GME regulations are invalid to the extent that they permit a determination of allowable GME base year costs for purposes of the per resident amount mehodology under section 1886(h) of the Act that deviates from the determination of allowable GME costs in the final, audited cost report for the base year itself.

41. Plaintiff filed an EJR petition under section 1878(f)(1) of the Act asking the Board to determine that it lacks the authority to decide the validity of the Secretary's reaudit regulations. By letter dated September 28, 1994, the Board determined that it did not have the authority to decide the validity of the Secretary's reaudit regulations. Accordingly, the Board granted plaintiff permission to seek judicial review of this issue.

42. Plaintiff received the Board's "EJR determination" on October 3, 1994. Accordingly, this suit is timely filed within 60 days of the date on which plaintiff received the Board's EJR determination.

VIII. INVALIDITY OF SECRETARY'S REAUDIT REGULATION

43. The Secretary's GME reaudit regulation is invalid because it conflicts with the Medicare statute. Section 1886(h)(2)(A) of the Act requires the Secretary to use as the numerator in the GME per resident amount methodology the "amount recognized as reasonable under this title for direct graduate medical education costs of the hospital" in the base year. However, the Secretary's regulation allows the intermediary to use an entirely different amount as the numerator in the formula, and the intermediary has, in fact, done so in this case. Where, as here, the "amount recognized as reasonable under this title for direct graduate medical education costs" in the

base year is *final* (*i.e.*, no longer subject to reopening), the Secretary is legally bound to use that "amount" for purposes of the GME per resident amount methodology.

44. The Secretary's reaudit regulation is also invalid because it is a retroactive rule. It is well-established that an administrative agency may not issue a retroactive rule unless it has express statutory authority to do so. *Bowen v. Georgetown University Hospital*, 109 U.S. 468 (1988). It is also well-established that the general rulemaking provisions in the Medicare statute do not authorize the Secretary to issue retroactive rules. *Id.* There is nothing in section 1886(h) of the Act that would authorize the Secretary to issue a retroactive rule to upset the reopening standards and the document-retention standards in effect at the time of the GME statute's enactment.

45. The Secretary's reaudit regulation is also invalid because it is arbitrary and capricious. The Secretary has previously recognized that rates under a prospective payment system must be set as quickly as possible. Yet, even though the GME per resident amount methodology is a prospective payment system, the Secretary waited three and a half years after enactment of section 1886(h) of the Act to issue regulations and then waited an additional year and a half to conduct and complete reaudits. In those reaudits, the Secretary used more rigorous standards than were in effect during the base year itself. Moreover, the reaudits were conducted at a time when the base year cost reports were no longer subject to reopening, when hospitals were no longer legally required to retain the base year documentation necessary for an audit, and when, for many hospitals, the financial personnel who were at the hospital during the GME base year were no longer employed by the hospital. The Secretary's tactics have caused great prejudice and distress to many hospitals, including plaintiff.

46. The Secretary's reaudit regulation is also otherwise contrary to law.

IX. REQUESTED RELIEF

WHEREFORE, plaintiff requests:

(1) A declaration that the Secretary's reaudit regulation is invalid;

(2) A declaration that the Secretary must use the final GME "reasonable cost" determination applicable to the GME base year itself in applying the per resident amount methodology of section 1886(h) of the Act;

(3) An order requiring that, to the extent that the Secretary has made (or has recouped) payment under the GME per resident amount methodology prior to decision in this case, the Secretary recompute plaintiff's entitlement in accordance with the preceding subparagraph and, within sixty days of the date of the court judgment, pay plaintiff the additional amounts due, plus interest in accordance with 42 U.S.C. § 1395oo(f)(2);

(4) An order requiring the Secretary to act in accordance with subparagraph (2) above in computing all future payments under the GME per resident amount methodology;

(5) Legal fees and costs of suit incurred by plaintiff; and

(6) Such other relief as this Court deems just and appropriate.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

(Title Omitted)

ANSWER

Donna E. Shalala, Secretary of Health and Human Services [the "Secretary"], defendant, answers the complaint as follows:

FIRST DEFENSE

Plaintiff has failed to state a claim upon which relief can be granted.

SECOND DEFENSE

With respect to the following corresponding numbered paragraphs of the complaint:

1. This paragraph characterizes the lawsuit from plaintiff's perspective, and no answer is required. However, if an answer be deemed necessary, deny.

2. Admit.

3. Admit the first sentence and the second sentence, except to deny that the audit was necessarily a "*final*" audit. Deny the third sentence.

4. Deny, except to admit that final regulations implementing the GME statute were issued in September, 1989.

5. Admit the first sentence. Deny the second sentence. Admit the remaining sentences, except to deny the allegation that the determination of plaintiff's allowable GME base year costs was a determination made "[n]ot surprisingly under all these circumstances."

6. This paragraph recites plaintiff's legal contention as to which no answer is required. However, if an answer is deemed necessary, deny.

7. Admit.

8. Deny, except to admit the Court has jurisdiction under 42 U.S.C. 1395oo(f)(1).

9. Admit.

10. Admit.

11. Admit.

12. Admit.

13. Admit.

14. Admit that the cited statutory and regulatory provisions say what they say, and the Court is respectfully referred to those provisions for a full statement of their contents. Otherwise, deny.

15. Admit this is a generally accurate statement of the "cost reimbursement" system. Otherwise, deny.

16. Admit.

17. Admit.

18. Admit.

19. Admit.

20. Admit.

21. Admit.

22. Admit.

23. Admit.

24. Admit that the cited statutory provisions say what they say, and the Court is respectfully referred to those provisions for a full statement of their contents. Otherwise, deny.

25. Deny, except to admit the second and third sentences.

26. Admit.

27. Admit the first sentences, except the allegation that these actions had been taken for "virtually all" hospitals. Admit the second sentence. Deny the third sentence, except to admit that the cited regulations and case say what they say, and the Court is respectfully referred to the regulations and the case report for a full statement of their contents.

28. Admit the first and second sentences. Deny the third sentence.

29. Admit that the regulations do not require the intermediaries to compute a hospital's payment amount under the GME per resident amount methodology solely on the basis of the amount recognized as reasonable in the hospital's base year cost report issued with the hospital's base year NPR; admit that the regulations authorize the Medicare intermediaries to reaudit a hospital's base year; and admit that the preamble to the rule contains the quoted language. Otherwise, deny.

30. Admit the regulations say what they say, and the Court is respectfully referred to those regulations for a full statement of their contents. Otherwise, deny.

31. Admit the preamble to the rule says what it says, and does not say what it does not say. Otherwise, deny.

32. Deny, except to admit the portion of the second sentence following the word "[i]nstead," and to admit the third sentence.

33. Admit.

34. This paragraph contains plaintiff's contentions and legal positions, as to which no answer is required. However, if an answer is deemed required, deny.

35. Admit.

36. Admit the first sentence. Deny the second sentence.

37. Admit.

38. Admit, except to deny the first clause of the first sentence and to deny the last sentence.

39. Admit.

40. Admit the first sentence. The remaining sentences contain plaintiff's legal contentions as to which no answer is required, but if an answer is deemed required, deny.

41. Admit.

42. Admit.

43. Deny.

44. Deny.

45. Deny.

46. Deny.

Defendant denies that plaintiff is entitled to the relief it requests in Part IX of the complaint, or to any relief.

Defendant specifically denies each and every allegation to which an answer has not previously been given.

Having answered the complaint, defendant requests that the Court enter judgment in her behalf, and grant defendant such other and further relief as may be appropriate and just.

Excerpts from 54 FED. REG. 40,315-40,319 (1989)*

§ 412.113. Payments determined on a reasonable cost basis.

* * * *

(b) *Direct medical education costs.* (1) Payment for the direct medical education costs of interns and residents in approved programs for cost reporting periods beginning prior to July 1, 1985, and for approved education activities of nurses and paramedical health professionals is made as described in § 413.85 of this chapter.

(2) For cost reporting periods beginning on or after July 1, 1985, payment for the direct medical education costs of interns and residents in approved programs is made as described in § 413.86 of this chapter.

(3) Except as provided in § 413.86(c)(1) of this chapter, for cost reporting periods during the prospective payment transition period, the costs of medical education must be determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate as provided in subpart E of this part.

§ 413.86 Direct graduate medical education payments.

(a) *Statutory basis and scope*—(1) *Basis.* This section implements section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section applies to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

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* Includes correction of technical errors in 55 Fed. Reg. 299 (1990).

(b) *Definitions.* For purposes of this section, the following definitions apply:

"Approved geriatric program" means a fellowship program of one or more years in length that is approved by the Accreditation Council for Graduate Medical Education (ACGME) under the ACGME's criteria for geriatric fellowship programs in internal medicine and family practice.

"Approved medical residency program" means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in § 405.522(a) of this chapter.

(2) May count towards ceritification of the participant in a specialty or subspecialty listed in the *Directory of Residency Training Programs* published by the American Medical Association.

(3) Is approved by the Accreditation Council For Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

"Base period" means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.

"CPI—U" stands for the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics.

"Foreign medical graduate" means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:

(1) The Liaison Committee on Medical Education of the American Medical Association.

(2) The American Osteopathic Association.

(3) The Commission on Dental Accreditation.

(4) The Council on Podiatric Medical Education.

"*FMGEMS*" stands for the Foreign Medical Graduate Examination in the Medical Sciences (Part I and Part II).

"*FTE*" stands for full-time equivalent.

"*Medicare patient load*" means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

"*Resident*" means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required by the order to become certified by the appropriate specialty board.

(c) *Payment for graduate medical education costs—General rule.* Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved graduate medical education programs as described in paragraph (d) through (h) of this section.

(d) *Calculating payment for graduate medical education costs.* A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

(1) *Step one.* The hospital's updated per resident amount (as determined under paragraph (e) of this section) is multiplied by the actual number of FTE residents (as determined under paragraph (g) of this section). This result is the aggregate approved amount for the cost reporting period.

(2) *Step two.* The product derived in step one is multiplied by the hospital's Medicare patient load.

(3) *Step three.* The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding graduate medical education costs attributable to each part as determined through the Medicare cost report.

(e) *Determining per resident amounts for the base period*—(1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, in-

cluding those previously allowed under § 412.113(b)(3) of this chapter; and

(C) Upon a hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(iv) If the intermediary modifies a hospital's base-period graduate medical education costs as described in paragraph (e)(1)(ii)(B) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(1) of this section.

(v) The intermediary notifies each hospital that either had direct graduate medical education costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984 and before October 1, 1985 of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(2) *For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986.* For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(i) If a hospital's base period began on or after October 1, 1983 and before July 1, 1984, the amount is adjusted

by the percentage change in the CPI—U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this action apply. The adjusted amount is then increased by one percent.

(ii) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

(3) *For cost reporting periods beginning on or after July 1, 1986.* For cost reporting periods beginning on or after July 1, 1986, each hospital's per resident amount for the previous cost reporting period is adjusted by the projected change in the CPI—U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI—U that occurred during the cost reporting period.

(4) *Exceptions*—(i) *Base period for certain hospitals.* If a hopsital did not have any approved medical residency training programs or did not particpate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Any graduate medical education program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. The per resident amount is based on the lower of the following:

(A) The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(B) The mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under Part 412 of

this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the mean value, the intermediary must contact HCFA Central Office for a determination of the appropriate amount to use.

(ii) *Short or long base-period cost reporting periods.* If a hospital's base-period cost reporting period reflects graduate medical education costs for a period that is shorter than 50 weeks or longer than 54 weeks, the intermediary converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or 366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(iii) *Short or long cost reporting periods beginning on or after July 1, 1985.* If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's intermediary should contact HCFA Central Office to receive a special CPI—U adjustment factor.

(f) *Determining the total number of FTE residents.* (1) Subject to the weighing factors in paragraphs (g) and (h) of this section, the count of FTE residents is determined as follows:

(i) Residents in an approved program working in all areas of the hospital complex may be counted.

(ii) No individual may be counted as more than one FTE. If a resident spends time in more than one hospital or, except as provided in paragraph (f)(1)(iii) of this section, in a nonprovider setting, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of time worked as compared to the average time spent by other residents working in the same specialty program.

(iii) On or after July 1, 1987, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:

(A) The resident spends his or her time in patient care activities.

(B) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

(2) To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information.

The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(i) The name and social security number of the resident.

(ii) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(iii) The dates the resident is assigned to the hospital and any hospital-based providers.

(iv) The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any.

(v) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

(vi) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of paragraph (h) of this section.

(vii) The name of the employer paying the resident's salary.

(g) *Determining the weighted number of FTE residents.* Subject to the provisions in paragraph (h) of this section, HCFA determines a hospital's number of FTE residents by applying a weighting factor to each resident and then summing the resulting numbers that represent each resident. The weighting factor is determined as follows:

(1) For purposes of this section, an initial residency period is the number of years necessary to satisfy the minimum requirements for certification in a specialty or subspecialty, plus one year. An initial residency period may not exceed five years in order to be counted toward determining FTE status except in the case of fellows in an approved geriatric program whose initial residency period may last up to two additional years.

(i) For residency programs other than those specified in paragraphs (g)(1)(ii) and (g)1)(iii) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the 1985-1986 Directory of Residency Training Programs.

(ii) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 405.522(a) of this chapter.

(iii) For residency programs in geriatric medicine approved by the ACGME, as set forth in later editions of the directory specified in paragraph (g)(1)(ii) of this section, these programs are considered approved programs retroactively to the latter of—

(A) The starting date of the program within a hospital; or

(B) The hospital's costs reporting period beginning on or after July 1, 1985.

(iv) The time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs, as described in paragraph (b) of this section, is counted toward the initial residency period limitation.

(2) If the resident is in an initial residency period, the weighting factor is one.

(3) If the resident is not in an initial residency period, the weighting factor is 1.00 during the period beginning on or after July 1, 1985 and before July 1, 1986, .75 during the period beginning on or after July 1, 1986 and before July 1, 1987 and is .50 thereafter without regard to the hospital's cost reporting period.

(h) *Determination of weighting factors for foreign medical graduates.* (1) The weighing factor for a foreign medical graduate is determined under the provisions of paragraph (g) of this section if the foreign medical graduate—

(i) Has passed FMGEMS; or

(ii) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(2) Before July 1, 1986, the weighting factor for a foreign graduate is 1.0 times the weight determined under the provisions of paragraph (g) of this section. On or before July 1, 1986 and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (h)(1) of this section is .50 times the weight determined under the provisions of paragraph (g) of this section.

(3) On or after July 1, 1987, these foreign medical graduates are not counted in determing the number of FTE residents.

(4) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of paragraph (g) of this section for the part of the cost reporting period beginning with the month the resident passes the test.

(5) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section.

(i) *Special rules for States that formerly had a waiver from Medicare reimbursement principles.* (1) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1 or section 222 (a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b-1 (note)) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(2) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(3) Per resident amounts are determined for the base period and updated as described in paragraph (e) of this section. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in paragraph (d) of this section.

(j) *Adjustment of a hospital's target amount or prospective payment hospital-specific rate*—(1) *Misclassified*

operating costs—(i) *General rule.* If a hospital has its base-period graduate medical education costs reduced under paragraph (e)(1) of this section because those costs included misclassified operating costs, the hospital may request that the intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its rate of increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(2) *Misclassification of graduate medical education costs*—(i) *General rule.* If costs that should have been classified as graduate medical education costs were treated as operating costs during both the graduate medical education base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate medical education costs in the graduate medical education base period,

the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.